PI - Quarterly Case Selection for Provider Reviews

Purpose:

Determine a specific number of providers to be audited in each quarter by the size of the provider groups and number and complexity of claims to be reviewed

Identification of Roles:

IME Program Integrity (PI)—establish the annual review schedule.

Performance Standards:

Open a minimum of 60 cases for provider reviews during each quarter. Review cases must include both providers that exceed calculated norms, and a random sample of providers who do not exceed norms.

Path of Business Procedure:

The PI annual review schedule is organized on a quarterly workflow calendar. Over the course of four quarters, all provider groups are screened to determine those that may warrant a closer review. This is indicated by analysis of Medicaid Management Information System (MMIS) Surveillance Utilization Review Services (SURS) Subsystem Reports. These reviews are referred to as Mandatory Federal Reviews (MFR).

The Account Manager, along with the Account Manager, Operation Manager, and Database Management Administrator revise or update the annual review plan, with a goal of even distribution and workload through each quarter. The distribution is based on analysis of dollars and numbers of claims paid to provider groups, as well as logical grouping of categories of service and provider classification.

Step 1. The Operations Manager, or designee, initiates the quarterly analysis on the first day SURS Subsystem Reports are available for each targeted provider.

Step 2. The Account Manager, along with the Operation Manager, and Database Management Administrator complete an analysis of all applicable reports for provider types targeted for the appropriate quarter.

Step 3. By the end of the first month of a quarter, the Account Manager, along with the Operation manager, and Database Management Administrator identifies

records and claims to be reviewed in the following quarter, based on the following.

a. The MFR annual schedule of quarterly reviews

1. Determine a specific number of providers to be audited in each review by the size of the provider groups and number and complexity of claims to be reviewed

2. Determine review foci and targeted providers by analysis of recipient data (provider driven) and treatment data (e.g., upcoding, inappropriate procedure codes, etc., or through the record review

b. Focused Reviews (FR) determined as problems are identified.

1. Analyze returned explanation of Medicaid benefits (EOMB)

2. Assess and process all referrals

3. Identify trends and patterns in MFR

4. Assess issues identified by PI staff or other IME units

Step 4. Under the Account Manager or designee's, direction identified records and claims are requested for review in the following quarter.

Step 5. Requests for records are typically mailed Tuesday through Friday.

Step 6. As reviews are completed and results compiled, MFR are reviewed retrospectively for performance and productivity. (Refer to Process for Continuous Review and Improvement of Quarterly Reports.)

a Use historical data and outcomes to guide and sharpen foci in planning follow-up and future reviews.
b. Organize and store historical data in electronic form on the PI shared drive.
c. Organize electronic files by initial focus of the review, provider type, other issues raised, and outcomes of any resulting appeals.
d. Review and discuss at Operations Assessment Committee meetings and staff meetings, as indicated.

Step 7. Referrals from other units of the IME (e.g., Medical Services, Provider Services, Member Services, or Policy), Department of Human Services, Department of

Inspections and Appeals, or any external entity also are investigated and assessed for integration into the review cycle, as indicated.

Forms/Reports:
None

RFP Reference:
6.1.2.1.11
6.1.3

Interfaces:
Program Integrity
CORE MMIS

Attachments:
None